

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G387 3/29/67 bc

03699

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03693

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waterloo</b> c. LENGTH OF STAY IN 1b <b>Waterloo</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Arundel Corp. Gravel Pit off Waterloo Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b> d. STREET ADDRESS <b>1840 Woodside Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM LLOYD ABSHER</b>		4. DATE OF DEATH Month <b>3</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-7-37</b>
9. AGE (In years lost birthday) yrs. <b>30</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>22</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Arundel Corp.</b>	11. BIRTHPLACE (State or foreign country) <b>Hayes, North Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Absher</b>	
14. MOTHER'S MAIDEN NAME <b>Walsie Johnson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Box 7, Hammonds Ferry Road Mrs. Higgins, Linthicum Hgts. Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> DUE TO (b) <b>9731</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute ethylism</b>			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found in truck- Engine running - hose from exhaust into cab of truck</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>?</b> p.m. <b>3 22 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Roadway</b>
20f. (City or town) (County) (State) <b>Howard Md.</b>		21. I certify that I took charge of the remains described above, held an <del>XXXXXX</del> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D.		22. DATE SIGNED <b>3-22-67</b>	
EXAMINER'S NAME (Type) <b>RUSSELL S. FISHER, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-25-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Baptist Church Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Traphill, North Carolina</b>
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		25a. REC'D BY REGISTRAR <b>MAR 27 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

MEDICAL CERTIFICATION

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• **Checklist:**

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03700

03694

1. PLACE OF DEATH a. COUNTY <u>Howard</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural- West Friendship</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pfefferkorn Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural- West Friendship</u> d. STREET ADDRESS <u>Pfefferkorn Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>A.</u> Last <u>Arrington</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1908</u> 9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>8</u> IF UNDER 24 HRS.: Hours <u>5</u> Min. <u>8</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Hobbs</u>		14. MOTHER'S MAIDEN NAME <u>Emma Flowers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-22-9684</u>	
17. INFORMANT <u>MR. R. N. Arrington - West Friendship, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 DUE TO (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>14 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/16/1967</u> , 19 <u>67</u> , to <u>3/3/1967</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/16/1967</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Parker M.D.</u>		22b. DATE SIGNED <u>3/5/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. PARKER, M.D.</u>		22d. ADDRESS <u>SOUTH BALTO GEN. HOSPITAL BALTO</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight Lykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MAR 5 1967

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03701						03695					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			Howard			a. STATE			Md		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Fulton			b. COUNTY			Howard		
c. LENGTH OF STAY IN						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Fulton		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			Md. Route # 216			d. STREET ADDRESS			Md. Route # 216		
3. NAME OF DECEASED (Type or print)			John (Nona) Bassler			4. DATE OF DEATH			March 11 1967		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dec 5 1897		72 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer				Dairy farm				Howard Co Md		U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
John Gustave Bassler						Dora Decker					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				218-36-2332		Mrs. Haster Bassler (wife)		same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerosis of Brain										4 yr	
334X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Garcinoma of Prostate											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
19											
21. I certify that (I) (this hospital) attended the deceased from Jan 5 1967 to March 11, 1967, that (I) (we) last saw the deceased alive on March 10 1967, and that death occurred at 6:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
ROBERT S. McCENEY, M. D.						402 MAIN ST.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE OF BURIAL, CREMATION, REMOVAL				23c. LOCATION (City, town or county) (State)			
Burial				3-14-67				St Pauls Lutheran Fulton Md			
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Delbert J. Janssen, Samuel Md						MAR 14 1967			Charles J. Janssen		

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ROBERT & MOONEY M.  
100 MAIN ST.  
LAUREL, CALIF. 9010

MAR 1 1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
03702					CERTIFICATE OF DEATH					03696					
1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route 99</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b> d. STREET ADDRESS <b>Route 99</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>GEORGIA H. CISSEL</b> First Middle Last					4. DATE OF DEATH <b>Mar. 22, 1967</b> Month Day Year										
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-28-1877</b>		9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>John Hobbs</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Ridgely</b>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mr. Brown Cissel</b>			Address <b>Marriottsville, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infection</b> <b>4221</b> DUE TO (b) <b>Atherosclerotic Cardiovascular disease</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2</b> <b>10 yrs.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>3-29</b> , 19 <b>66</b> , to <b>3-22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>2-16</b> , 19 <b>67</b> , and that death occurred at <b>10 P</b> M, from the causes and on the date stated above.															
22a. SIGNATURE <b>Thomas F. Herbert</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-23-67</b>								
22c. PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert</b>					M.D.		22d. ADDRESS <b>44 Church Road, Ellicott City, Md</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>3-25-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Howard Co. Md.</b>							
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>					ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
03703					03697									
1. PLACE OF DEATH a. COUNTY Howard MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City 13-1									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 22 Tyler Drive					d. STREET ADDRESS 22 Tyler Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last RUSSELL CARL HEASLEY SR					4. DATE OF DEATH Month Day Year March 1, 1967 19									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1913		9. AGE (In years last birthday) 54 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Area Coordinator		10b. KIND OF BUSINESS OR INDUSTRY Reuben H. Donnelley		11. BIRTHPLACE (County & State, or foreign country) Penn, Penna.			12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME David C. Heasley					14. MOTHER'S MAIDEN NAME Ada Rayger									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 175-03-7850		17. INFORMANT Mrs. Jacqueline Heasley, Ellicott City, Md										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, lung, metastatic</i> 165X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 mos.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from 12-16, 1963, to 3-1, 1967, that (I) (we) last saw the deceased alive on 2-27, 1967, and that death occurred at 1:30 PM, from the causes and on the date stated above.														
22a. SIGNATURE Thomas F. Herbert					22b. DATE SIGNED 3-2-67			22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.						
22d. ADDRESS Ellicott City, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-1967		23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City, town or county) (State) Ellicott City, Md								
24. FUNERAL DIRECTOR F.C. Higginbotham, Ellicott City, Md					25a. REC'D BY REGISTRAR MAR 3 1967					25b. REGISTRAR'S SIGNATURE J. Charles Judge				

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## CERTIFICATE OF DEATH

03698

03704

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fulton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ----		d. STREET ADDRESS <b>310 Rittenhouse St. N.W.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Blanche S. Holtzclaw</b>		4. DATE OF DEATH Month Day Year <b>MARCH 7 1967</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/16/82</b>
9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick Pfeiffer</b>		14. MOTHER'S MAIDEN NAME <b>Bettie White</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mary Margaret Simons same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>CORONARY SCLEROSIS</b> DUE TO (b) <b>20 YEARS</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/30, 1960</b> , to <b>3/7, 1967</b> , that (I) (we) last saw the deceased alive on <b>MAR 3 1967</b> , and that death occurred at <b>6:50 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles S. Whitaker</b>		22b. DATE SIGNED <b>3/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, MD</b>		22d. ADDRESS <b>CLARKSVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3/10/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges County, Md.</b>	
24. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>MAR 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

030308

CERTIFICATE OF DEATH

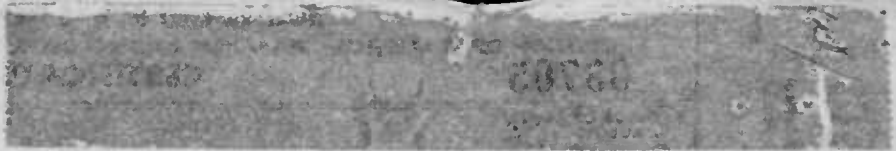
03704

MAY 10 1967

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03705 CERTIFICATE OF DEATH 03699

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hanover		c. LENGTH OF STAY IN b 22yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hanover		d. STREET ADDRESS Florey Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Florey Rd., Hanover, Md.		3. NAME OF DECEASED (Type or print) William Henry Lomax		First Middle Last		4. DATE OF DEATH March 21, 1967		Month Day Year		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4, 1876		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Plasterer		11. BIRTHPLACE (County & State, or foreign country) Calvert Co - Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME late George Richard Lomax		14. MOTHER'S MAIDEN NAME late Elisa													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT George W. Lomax		Address Florey Rd. Hanover Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } (c) 5720		apoplexy in left hemisphere Cardio-Vascular disease		INTERVAL BETWEEN ONSET AND DEATH 2 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Cervix 10 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from Jan 27 1967 to Mar 21 1967, that (I) (we) last saw the deceased alive on Mar 20 1967, and that death occurred at 8:30 PM, from the causes and on the date stated above.		22a. SIGNATURE B B Brombaugh M.D.		22b. DATE 3/21/67											
22c. PHYSICIAN'S NAME (Type) B B Brombaugh		22d. ADDRESS 2609 main st Baltimore Md													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 24 '67		23c. NAME OF CEMETERY OR CREMATORY Lady Star of Sea Church		23d. LOCATION (City, town or county) Solomons Island - Calvert Co.									
24. FUNERAL DIRECTOR'S SIGNATURE Witzke		ADDRESS 4101 Edmondson Ave Balto. Md.		25a. REC'D BY REGISTRAR DATE MAR 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge									



03000

Flory, Ed., Hanover, Mo.

Flory, Ed. - Maryland

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03700

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>Years</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> 13-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Underwood Road</b>			d. STREET ADDRESS <b>Underwood Road</b>		
3. NAME OF DECEASED (Type or print) <b>ROLLAND C. MASEK, Jr.</b>			4. DATE OF DEATH <b>Mar. 19, 1967</b> 19 <b>67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1944</b>	9. AGE (in years lost birthday) <b>22 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Roland C. Masek, Sr.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>?</b>		
17. INFORMANT <b>Mr. Roland Masek, Sr.</b>			Address <b>Sykesville, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b> 9731 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Thomas F. Herbert</b>		M.D. <b>Thomas F. Herbert M D</b>		22. DATE SIGNED <b>3-19-1967</b>	
EXAMINER'S NAME (Type) <b>Thomas F. Herbert</b>		ADDRESS <b>44 Church Road, Hyattsville, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-22-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	23d. LOCATION (City or Town) <b>Hyattsville,</b>	(County) <b>Md.</b>	(State)
24. FUNERAL DIRECTOR <b>Harry W. Knight</b>			ADDRESS <b>Sykesville, Md</b>	25a. REC'D BY REGISTRAR <b>MAR 21 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

03300

03300

FOR STATE  
HEALTH DEPT.

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3500 4-64

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03707

03701

1. PLACE OF DEATH a. COUNTY <b>HOWARD,</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>How.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - LAUREL</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL - LAUREL</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1801 SCAOGSVILLE ROAD</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>FRANKLIN JACOB REEDER</b>				4. DATE OF DEATH <b>MARCH 19 1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-2-06</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERINTENDANT</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>SAND &amp; GRAVEL CO.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>CHARLES REEDER</b>				14. MOTHER'S MAIDEN NAME <b>FLORENCE EOLAR</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>215030155</b>		17. INFORMANT <b>MRS. JACOB REEDER - SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC FAILURE</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY THROMBOSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>INST.</b> <b>INST.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Whitaker,</b>				22. DATE SIGNED <b>3/19/67</b>			
EXAMINER'S NAME (Type) <b>CHARLES S. WHITAKER, MD.</b>				DEPUTY MEDICAL EXAMINER <b>CLAUDE S. ELLIOTT, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <b>3-21-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem</b>	
24. FUNERAL DIRECTOR <b>W. A. Connors</b>				23d. LOCATION (City, town or county) (State) <b>Calmar, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

03301

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44 38 387